



PEDIATRIC OFFICE OF M. ABUNTO, MD & M. TOLENTINO, MD

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**AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH
INFORMATION**

PATIENT'S NAME : _____ DATE OF BIRTH : _____

ADDRESS : _____ TEL : _____

I hereby authorize the office of Dr M. Abunto & Dr M. Tolentino to use and disclose my health information for the purposes of healthcare operations, treatment and payment activities.

DURATION : This authorization shall become effective immediately and shall remain in effect until _____.

REVOCAION : This authorization is subject to written revocation by me at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDISCLASURE : I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Date : _____ Signature : _____

If signed by other than patient, indicate relationship : _____

Name of representative : _____